IA-2 WORKERS COMPENSATION – SUBSEQUENT REPORT

Employee Name (last, First, Middle)	Social Security Number	Date of Injury	Report Effective Date	Jurisdiction

Date Disability Began	Pre-Existing Disability? ☐ YES ☐ NO	Date of Representation	Date of Death	Report Purpose

Released/Returned to Work (RTW) Date	Released /RTW Qualifier			Jurisdiction Claim Number
	☐ RTW Without Restrictions	☐ Released RTW Without Restrictions		
	☐ RTW With Restrictions	☐ Released RTW With Restrictions		

# of Dependents	Death Dependent/ Payee Relationship (insert #)						Date of Maximum Medical Imprvmnt?
	☐ Widow	☐ Children	☐ Parents	☐ Jurisdiction Fund			
	☐ Widower	☐ Siblings	☐ Handicapped Children	☐ Other			

Permanent Impairment	Body Part	Percent	Body Part	Percent	Body Part	Percent

Employer Name	FEIN	Insured Report Number

WAGE

Wage Period ☐ Weekly ☐ Monthly	Average Wage	Effective Date of Average Wage Change	Comp Rate	Effective Date of Comp Rate Change	# Days Worked Per Week	Salary Continued in Lieu of Comp? ☐ YES ☐ NO

PAYMENT

Payment Type	Weekly Pymt Amnt	Amount Paid to Date	Paid From (MM/DD/YY)	Paid Through (MM/DD/|YY)	# Weeks Paid	# Days Paid

BENEFIT ADJUSTMENTS

Benefit Adjustment Type	Weekly Amount (+ or -)	Start Date	Benefit Adjustment Type	Weekly Amount (+ or -)	Start Date

PAID-TO-DATE / **REDUCED EARNINGS**

Paid to Date (PTD Type)	PTD Amount	Actual/ Deemed	WK #	Weekly Earnings	Actual/ Deemed	WK #	Weekly Earnings

RECOVERIES

Recovery Type	Recovery Amount						

CLAIM ADMINISTRATION

Insurer Named	FEIN	Claims Status			
			☐ Open	☐ Reopened	
			☐ Closed	☐ Reopened/Closed	

Third Party Administrator Name	FEIN	Claim Type			
			☐ Medical Only	☐ Notification Only	☐ Became Lost Time
			☐ Indemnity	☐ Became Med Only	☐ Transfer

Claim Administrator Claim Number	Agreement to Compensate	
		☐ Without Liability
		☐ With Liability

Claim Administrator Address (Include City, State, Postal Code, and Phone Number)	Late Reason	
	Date Prepared	Page ____ of ____.